

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add  
 C = Change  
 D = Delete

Amendment Number

DOCUMENT CODE  
3

2. COUNTRY/ENTITY

INTERREGIONAL

3. PROJECT NUMBER

932-0955

4. BUREAU/OFFICE

S&T/POP

36

5. PROJECT TITLE (maximum 40 characters)

FAMILY PLANNING INTERNATIONAL ASSISTANCE

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY  
06 30 89

7. ESTIMATED DATE OF OBLIGATION  
(Under "B." below, enter 1, 2, 3, or 4)

A. Initial FY 83 B. Quarter 2 C. Final FY 87

8. COSTS (\$000 OR EQUIVALENT \$1 = )

A. FUNDING SOURCE	FIRST FY 83 *			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AD Appropriated Total	13,250		13,250	191,500		191,500
(Grant)	(13,250)	( )	(13,250)	(191,500)	( )	(191,500)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country						
Other Donor(s)						
<b>TOTALS</b>	<b>13,250</b>		<b>13,250</b>	<b>191,500</b>		<b>191,500 2/</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PN	440	440		118,350		73,150		191,500	
(2)									
(3)									
(4)									
<b>TOTALS</b>				<b>118,350</b>		<b>73,150 1/</b>		<b>191,500 2/</b>	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code NA See Page 19, PP Part III "General Responsibilities"

B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

TO EXTEND THE AVAILABILITY OF FAMILY PLANNING INFORMATION AND SERVICES THROUGH EXISTING MEDICAL, SOCIAL AND WELFARE PROGRAMS OF LDC ORGANIZATIONS AND INSTITUTIONS.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY  
07 84 07 86

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000  911  Local  Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a page 11 Amendment)

\* This approval action

1/ Excludes in-kind contribution: estimated 370 million condoms; 120 million OC's through FY 1987. See page 16 pp.

2/ Includes prior obligations totalling \$118,350,000 FY 71 through FY 1982.

17. APPROVED BY

Signature: [Signature]  
Title: Deputy Director, S&T/POP

Date Signed MM DD YY  
06 12 89

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

## PROJECT AUTHORIZATION

Name of Entity: Interregional      Project Title: Family Planning International Assistance

Project No.: 932-0955

Grantee: Planned Parenthood Federation of America/Family Planning International Assistance (PPFA/FPIA)

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize an increase not to exceed \$73,150,000 in the level of funding of the centrally funded Family Planning International Assistance Project for a new life-of-project total of \$191,500,000, in grant funds for the period FY 1971 - FY 1987. Funding during the five-year period FY 1983 - FY 1987 will be in annual increments, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project.

2. The project is based on voluntarism and informed choice. It consists of activities to extend the availability of family planning information and services through existing medical and welfare institutions of developing countries.

3. The cooperative agreement or other agreement(s) which may be negotiated with the Planned Parenthood Federation of America/Family Planning International Assistance (PPFA/FPIA) and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following terms and conditions together with such other terms and conditions as A.I.D. may deem appropriate.

### 4. Source and Origin of Goods and Services

- a. Each developing country where training or other assistance takes place under this project shall be deemed to be a cooperating country for the purpose of permitting local cost financing.
- b. Goods and services, except for ocean shipping, financed by A.I.D. under the project shall have their source and origin in the cooperating country or in the United States except as A.I.D. may

otherwise agree in writing. Ocean shipping financed by A.I.D. under the project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

Clearances:

A.	S&T/POP:J.J. Speidel	<i>[Signature]</i>	Date	<u>2-16-83</u>
B.	S&T/PO:G. Eaton	<i>[Signature]</i>	Date	<u>2-16-83</u>
C.	S&T/HP:W. Paupe	<i>[Signature]</i>	Date	<u>2/18/83</u>
D.	S&T:N.C. Brady	<i>[Signature]</i>	Date	<u>2/18/83</u>
<i>C.B.</i>	E. GC:J. Mullen	<i>[Signature]</i>	Date	<u>3/10/83</u>
F.	PPC/PDPR:E. Humander	<i>[Signature]</i>	Date	<u>2-1-83</u>

*[Signature]*  
\_\_\_\_\_  
M. Peter McPherson  
Administrator  
April 6, 1983  
\_\_\_\_\_  
Date

ACTION MEMORANDUM FOR THE ADMINISTRATOR

THRU: ES  
THRU: AA/PPC, John R. Bolton  
FROM: SAA/S&T, N.C. Brady

*John R. Bolton*  
*N.C. Brady*  
APR 1 10 30 AM '83  
RECEIVED SECRETARIAT

**Action:** Your approval is requested for a grant of \$73,150,000 from Section T046 of the Population Development Assistance appropriation of the Foreign Assistance Act. The grant is required to continue support for the Planned Parenthood Federation of America/Family Planning International Assistance (PPFA/FPIA) Project No. 932-0955 through FY 1987.

It is planned that a total of \$13,250,000 will be obligated in FY 1983.

**Discussion:** Family Planning International Assistance (FPIA) is the International Assistance Division of the Planned Parenthood Federation of America. It was founded in 1971 in response to an A.I.D. requirement for U.S. intermediaries to assist family planning programs in developing countries. Its continuing goal is to enhance the freedom of individuals to choose voluntarily the number and spacing of children. It does so by making family planning information and services accessible through A.I.D.-approved LDC programs requesting family planning assistance.

A.I.D. has funded this project since 1971 under two successive grants to PPFA/FPIA. Cumulative obligations through FY 1982 have totaled \$118,350,000. The project assists primarily private sector institutions and countries not covered by A.I.D. bilateral country agreements. The purpose is twofold: to extend the availability of family planning services through existing medical and welfare institutions and to encourage assisted institutions and developing country governments to work toward greater assumption of financial support of programs from indigenous resources.

The demand for FPIA assistance is ubiquitous. To date, FPIA assistance has spanned four continents, involved more than 100 countries and helped more than 2,600 private sector institutions, organizations and government agencies in the delivery of voluntary family planning services. Between 1977 and 1981, FPIA assisted 176 subprojects in 38 countries. Of these, 47 were able to continue following phased withdrawal of FPIA support.

FPIA currently assists 103 projects in 32 countries and provides contraceptives for health/family planning programs in 49 countries. The most recent estimate is that about 3.7 million family planning clients have been served through the FPIA program.

During the next five years, FPIA plans to provide technical and financial assistance to about 100 family planning/population service, information and training projects annually in 40-50 countries and distribute family planning commodities to men and women primarily through non-government organizations and institutions, including charitable and church-related organizations in 50-60 developing countries. Some assistance will also be provided to develop family planning resources and services of government organizations involved in maternal/child health and rural health delivery systems.

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By the end of the project (FY 1987), it is expected that over five million persons will be using family planning services from FPJA-assisted organizations and over ten million persons will have been reached by FPJA-assisted information, education and communications activities.

The FPJA project has been periodically evaluated by teams of external evaluators. Each reported favorably on the pertinence and effectiveness of activities supported by FPJA and on FPJA's managerial performance. The most recent (May 1981) evaluation was conducted for A.I.D. by the American Public Health Association (APHA). The team stressed the strong, continuing need for private-sector involvement in population activities in developing countries. It commended FPJA for doing an excellent job of providing assistance to private voluntary organizations and host governments and recommended continuation of the AID/FPJA grant through FY 1987. The evaluation report is attached as Annex B of the Project Paper.

Justification to Congress: An Advice of Program Change is required to increase the Data Base life-of-project authorization level from \$118,350,000 to \$191,500,000 (ref. page 113). This project is cited on page 48 of Annex-V, Centrally Funded Programs, of the Congressional Presentation for FY 1983.

Clearances Obtained: The geographic bureaus have endorsed project continuation and rate FPJA as one of the top five highest priority projects among centrally funded population activities. Field missions also have participated in the project review process and are overwhelmingly supportive of the project. Comments from each regional bureau, S&T Bureau, GC, CM, and PPC have been received and incorporated in the project paper. The Sector Council review was held on January 13, 1983, requested changes have been made, and no outstanding issues remain. Minutes of that meeting are attached (Attachment 2).

Recommendation: That you sign the attached authorization.

Attachment:

1. Project Authorization
2. Sector Council Minutes 1/13/83
3. Project Paper (No. 932-0955)

Clearances:

GC: J. Mullen (Actg)	<i>JM</i>	Date: 3/17/83
PPC/PDPR: E. Mullander	<i>EM</i>	Date: 3-18-83
S&T/POP: J.J. Speidel	<i>JJS</i>	Date: 3-16-83
S&T/PO: G. Eaton	<i>GE</i>	Date: 3-16-83
S&T/HP: W. Paupe	<i>WP</i>	Date: 3-17-83

Drafted: S&T/POP/FPSD:JLoudis:emt:235-8675:02Mar83:wang 0183Y

V

FY 1983-87 PROJECT PAPER  
FAMILY PLANNING INTERNATIONAL ASSISTANCE

CONTENTS	Page
<b>PART I.</b>	
Summary and Recommendations	1-3
A. Face Sheet	
B. Recommendation	1
C. Summary Project Description	1
1. Program Goal	1
2. Project Purpose	1
3. Project Activities	1
D. Summary Findings	2
<b>PART II.</b>	
Detailed Project Description	3-15
A. Background	3
1. Funding History	3
a. Program Support	3
b. Commodity Support	3
c. Other Donor Support	3
2. Grant Evaluations	4
3. Accomplishments	4
a. Project Assistance	4
b. Commodity Assistance	5
c. Key Trends	5-7
B. Project Description	8
1. Program Goal	9-11
2. Project Purpose	12

3. Project Inputs and Outputs	13-14
a. A.I.D.	15-16
b. F.P.I.A./Host Country	17
4. Means of Verification	18
<b>PART III. Implementation Arrangement</b>	<b>19-28</b>
<b>A. FPIA and AID Administrative Arrangement</b>	
1. FPIA	19
a. Organizational Structure	19
b. General Responsibilities	19
c. Program Management and Planning	19
2. AID	20
a. Management Responsibilities	20
b. Subproject Proposals	21
<b>B. Implementation Plan</b>	22
<b>C. Implementation Procedures</b>	22
1. Proposal Requirements	22
2. Approval Criteria	23
3. Approval Procedures	24
4. Implementation Schedule	25
5. Accountability	25
6. Program Continuity	26
7. Country Policies	26
8. Site Visits and Travel	26
9. Coordination	27
<b>D. Professional and Consultant Personnel</b>	27
<b>E. Reporting</b>	28
<b>F. Evaluation</b>	28

PART IV.	Project Analysis	29
	A. Social Soundness Analysis	29
	B. Technical Analysis	30
	C. Economic Analysis	31-32
	D. Financial Plan	33-35
	E. Project Logical Framework	36
	F. Environmental Impact	37

#### ANNEXES

- A. Project Selection Criteria: Significance/Effectiveness
- B. Project Evaluation: Summary/Conclusions
- C. Project Summary: FPIA Performance 1977-1982
- D. Proposed Country/Subproject Obligations FY 1983 - FY 1987
- E. Policy Determination No. 70 and Addendum to PD-71 "AID Policy Guidelines on Voluntary Sterilization"
- F. Statutory Checklist
- G. Letter of Application
- H. Project Implementation Schedule

PROJECT PAPER  
PLANNED PARENTHOOD FEDERATION OF AMERICA  
FAMILY PLANNING INTERNATIONAL ASSISTANCE

Part I. Summary and Recommendations

A. Face Sheet - (attached)

B. Recommendation - That grant funds be contributed to the Planned Parenthood Federation of America (PPFA) to carry out program activities of its Family Planning International Assistance Division (FPIA) as follows:

Fiscal Year	1983	1984	1985	1986	1987
Grant Obligations (\$000)	13,250	13,400	15,000	15,500	16,000

C. Summary Project Description:

1. Program Goal - The goal is twofold: Enhance the freedom of individuals to choose voluntarily the number and spacing of children; and, encourage population growth consistent with the growth of economic resources and productivity.

2. Project Purpose - Extend the availability of Family Planning information and services through existing medical, social and welfare programs of IDC institutions/organizations.

3. Project Activities - To achieve the project purpose,

a. The FPIA will administer assistance for:

- o developing family planning (FP) programs which improve the status of women;
- o providing contraceptive information, supplies, FP commodities and Natural Family Planning (NFP) techniques to AID-approved LDC health/family planning programs;
- o expanding Community Based Distribution (CBD) networks;
- o expanding voluntary sterilization (VS) services;
- o extending family planning information and services to adolescents;
- o training paraprofessional program personnel; and
- o providing technical assistance for program administration, management and evaluation.

- b. FPIA will be responsible for the following activities:
- o supporting AID country-development strategies that require short-term technical advisory, project or commodity assistance;
  - o collaborating with related international agencies to ensure complementarity of in-country strategies, programs and services;
  - o providing technical assistance related to project:
    - development, planning and negotiation;
    - administration and management;
    - performance and accountability; and
    - commodity service and delivery
- c. During the period of the AID funding, FPIA will collaborate with AID to address major unmet needs. These include:
- o introducing family planning services into countries where services are unavailable or limited;
  - o extending services to underserved rural and remote areas; and
  - o supporting cost-efficient pilot activities that can be taken over, continued and expanded by LDC government or non-government organizations (NGO's).

D. Summary Findings: FPIA has been an AID grantee since 1971. It is now the major U. S. non-government donor agency providing population assistance to LDC private sector voluntary organizations.

Over the years, FPIA has achieved high recognition for its ability to respond to LDC needs and for implementing/managing international assistance programs in keeping with AID population assistance strategies. Annually, FPIA records steady increases in acceptance of family planning services and LDC requests for project and commodity assistance. The most recent external evaluation (June 1981) cited FPIA for its excellent assistance record and recommended continued AID support for at least the next five years.

In view of FPIA's performance to date, and on the basis of analyses described in this paper, AID considers this project to be technically and financially sound. It is AID's judgment that FPIA can attain the desired end-of-project conditions by 1988. The project meets all applicable statutory criteria (see Annex F).

## Part II. Detailed Project Description

A. Background: Between 1965 and 1970, the Church World Services (CWS), a corporate member of the National Council of Churches, developed a "Planned Parenthood Program" which provided information and stimulated awareness of the need for family planning services throughout the world. By 1970, the CWS program was serving a network of 1,200 protestant organizations in 81 countries.

In 1971, the Director of the CWS-Planned Parenthood Program considered a grant from AID to expand these activities. CWS however, decided not to accept AID funding, feeling that another agency might be freer to approach non-protestant groups and suggested that Planned Parenthood Federation of America be approached. This then led to the establishment of FPIA by PPFA in June 1971 with grant assistance from AID.

The initial AID grant authorized PPFA/FPIA to "provide developing country service organizations with financial, material and human resources to enable them to offer voluntary family planning services to increasing numbers of acceptors." Later, a second AID grant extended FPIA assistance to a wide range of social, welfare, women's and youth organizations and in some cases LDC governments and health institutions. FPIA was additionally authorized to select and assist innovative, cost-effective, low-cost technology projects (See Project Criteria Annex A) which have a good chance of continuing after phaseout of FPIA's support.

Since 1971, the grantee has supported over 370 projects in 41 countries. FPIA currently assists 103 projects in 32 countries and provides contraceptive commodities to health/family planning programs in 49 countries. FPIA estimates that 3.7 million family planning acceptors have been served through its projects and commodity distribution services.

### 1. Funding History:

a. Program Support - AID's first grant to PPFA/FPIA (AID/csd-3289) was for \$13.5 million; it covered the 51 month period from July 1, 1971 to September 30, 1975.

In FY 1976, AID and PPFA negotiated a second (successor) grant agreement to continue support for FPIA's assistance program. This grant agreement (AID/pha-G-1131) will expire March 31, 1983.

Through FY 1982, the total AID funds obligated for grant AID/pha-G-1131 amounted to \$77,409,957.

b. Commodity Support - AID has supplemented FPIA's dollar grants with in-kind contribution of pills and condoms. Copper T IUD's were added as an in-kind commodity in 1982. Responsibility for warehousing and shipping contraceptives for all of AID's centrally-funded Commercial Retail Sales projects was also added in 1982. Since 1971, in-kind commodity contributions have totaled about \$27.5 million bringing total AID support to about \$ 118,350,000.

c. Other Donor Support: Support from other donors has ranged from \$10,000 annually, in the early years of the FPIA program, to about \$213,000 in CY 1982.

2. Grant Evaluations: PFFA/FPIA operations have been evaluated four times. The first two evaluations (CY1973:1975) concentrated on PFFA/FPIA's organization and its ability to manage commodity distribution and FPIA-assisted projects overseas. The findings and recommendations served as a basis for designing the current grant agreement (AID/pha-G-1131) which was approved by AID through December 31, 1982.

The third and fourth evaluations were completed in June 1977 and July 1981. These evaluated the extent to which the grantee had achieved the project purposes and objectives specified in AID/pha-G-1131. The 1981 evaluation also reviewed FPIA criteria for country allocations as well as USAID and host country views or the relevance of FPIA-assisted projects to country priorities and development strategies.

After reviewing FPIA's performance, the 1981 evaluation team concluded that: FPIA is involved in vitally important family planning work around the world, concentrating on the large, important and rather neglected private sector. The team believed there is a strong, continuing need for private-sector involvement in IIC population activities and that FPIA has done an excellent job of providing assistance to IVO's and host governments. The team recommended continuation of the AID/FPIA grant through FY 1987. Those on the team who had evaluated other population projects found FPIA to be one of the best managed and capable organizations involved in family planning. Nevertheless, the team report included 29 findings and 25 recommendations in the Summary attached. A few were laudatory and recommended adapting FPIA techniques to other population programs or intermediaries; some were for AID or involved practices possibly forced on FPIA by AID requirements or by AID funding constraints. The majority concerned "fine-tuning" of FPIA's management system.

FPIA responded rapidly to the recommendations. By November 1981, FPIA had adjusted or revised key management operations, documented the changes with staff manuals, procedural memoranda, new forms or pamphlets, developed appropriate instructional curricula and established management training sessions for FPIA staff officers worldwide. Concomitantly, AID incorporated recommended changes into AID/pha-G-1131 or into the new agreement being proposed in this Project Paper.

3. Accomplishments: During the four year period from July 1, 1977 through June 30, 1981, FPIA family planning assistance to developing countries totaled \$53,611,397. This assistance was evenly split between FPIA project funding obligations (51%) and family planning commodity assistance orders (49%). The value of subproject obligations was \$27,080,036; commodity shipment orders, \$26,531,361.

a. Project Assistance: From Program Years (PY) 7 through 10, e.g. 1977-1981, FPIA assisted 176 active subprojects in 38 countries. Most subprojects emphasized delivery of contraceptive services (130); the remainder included information, education and communication (IIEC) (26) and training (20). Ninety-nine subprojects involved IIC private sector, secular organizations; 53 were with religious groups; 14 with government organizations. Since FPIA cannot provide long-term support for its programs, FPIA tries to help its grantee organizations develop income-generating schemes or secure funds from other sources before FPIA assistance terminates. Of the 176 completed projects, 47 have been able to continue with funds from other sources,

79 required no further support, 21 were redesigned and received partial FPIA assistance and the remainder were phased out with AID/USAID and host country concurrences.

b. Commodity Assistance: During Program Years 7 through 10, FPIA provided contraceptive commodities to over 1600 individual recipient institutions in 88 developing countries. The commodities ordered were mostly orals (about 70 million monthly cycles) and condoms (approximately 376 million pieces). East Asian and Latin American recipients accounted for the bulk of the assistance. Dollar values totaled \$9.5 and \$8.7 million for Latin America and East Asia, and reached \$5.2 and \$3.1 million each for Southwest Asia and Africa.

c. Key Trends: From PY 7 through PY 10, the number of active FPIA projects rose from 63 to 113; participating countries rose from 26 to 32. Africa projects quadrupled from 9 to 36; Latin America projects increased from 18 to 25; Southwest Asia from 14 to 29 and East Asia/South Pacific from 17 to 24. In this period, FPIA's annual subobligations increased from \$10.5 million in PY 7 to \$15.2 million in PY 10. Overall, dollar totals from African and Latin American countries rose substantially. Subobligations for East, Southwest Asia and South Pacific countries peaked in PY 8-9 and declined in PY 10.

An analysis of FPIA's proposed and actual project outputs from July 1, 1977 through December 31, 1982 appears on pages 6 and 7 of this Project Paper (PP). The analysis compares FPIA's annual accomplishments against performance targets specified in the July 1, 1977 Project Paper.

A more comprehensive accounting of FPIA's performance is attached as Annex C. This reports project and commodity assistance in terms of the quantities, types, costs and geographic locations of family planning activities funded by FPIA since July 1971. It summarizes both project and commodity growth trends, by dollar costs and regions served. It provides benchmark information upon which new family planning assistance programs may be planned for the 1980's.

\*The current Project Paper covers the grant period: July 1, 1977 through December 31, 1982.

II. A. 3 Summary: Projects accomplishments/outputs during the period FY 1978 through FY 1982

End of Project Objectives	Planned Outputs (FY 1978-82)	Progress Indicators	Actual Achievement (Indicators) Total Numbers of LDC's and people served				
			PY-7 7/1/77- 6/30/78	PY-8 7/1/78- 6/30/79	PY-9 7/1/79- 6/30/80	PY-10 7/1/80- 6/30/81	PY-11* 7/1/81- 6/30/82
(1) A well-staffed and fully utilized central headquarters operation			A C H I E V E D				
(2) Increased number of Regional Offices from four to six by splitting the Africa and Latin America offices into two Regional Offices in each continent.			Target changed. Four Regional Offices maintained through 1982. Further increases dependant upon AID population assistance strategy beyond FY 1982.				
(3) Central Headquarters and Regional Offices supporting management, financial, commodities, medical, IEC, training and evaluation project operations in LDC's.	Support capabilities and effectiveness determined by requests for services, performance reports, independent evaluations and other indices.	Requests for Project Assistance	75	91	175	129	132
		# Agencies that received FPFA commodity assistance	557	641	449	296	260 <sup>1/</sup>
		# of Performance Reports	207	328	401	574	556
(4) Family Planning commodities distributed to men and women thru institutions/agencies in 80-90 LDC's.	Distribution of 50 million cycles orals; 2,245,000 gross condoms and \$3,000,000 worth of other contraceptive and related FP equipment.	# pill cycles shipped	14,041,600	28,260,000 <sup>2/</sup>	16,448,600	11,211,600	12,000,000
		# condoms shipped	99,349,500	74,250,600	82,595,900	120,176,800	110,000,000
		\$ value of other FP commodity shipments	\$ 1,194,648	\$ 1,694,514	\$ 1,841,230	\$ 741,711	\$ 800,000
		# of LDC's receiving commodity assistance	64	62	61	57	53
		Estimated # of acceptors served by commodities (project acceptors excluded)	2,687,842	3,836,401 <sup>2/</sup>	2,789,500	2,398,219	2,500,000
(5) Training Projects and related training activities for physicians and paraprofessional in 5-10 LDC's.	5-10 training projects training 300 physicians; 1,500 paraprofessionals.	# of Training Projects	6	10	8	11	3
		# of LDC's with Training Proj.	4	5	4	4	3
		# of Physicians trained	372	1,571 <sup>3/</sup>	585	873	500
		# of Para-Professionals	896	4,043 <sup>4/</sup>	5,645	670	145

<sup>1/</sup> Decrease attributed to termination of mass mailing program for voluntary F.P. Agencies; Bangladesh

<sup>2/</sup> Peaks attributed to request for 15.0 million orals by Government of Indonesia and decline in PY 9-10 for orals for Bangladesh and Philippines.

<sup>3/</sup> 1,300 Ayurvedic Physicians trained PY-8; Sri Lanka projects

<sup>4/</sup> 7,200 Nurse Midwives trained PY 8 and 9; Mexico projects

\* estimated projections based on 7/1/81 - 12/31/81 data

II.A.3 Summary: Project accomplishments/outputs during the period FY 1978 through FY 1982

End of Project Objectives	Planned Outputs (FY1978-82)	Progress Indicators	Actual Achievement (Indicators) Total Numbers of LDC's and people served				
			PY-7	PY-8	PY-9	PY-10	PY-11*
(6) Women's projects to be implemented in 5-10 countries.	10-15 projects through women's organizations.	} # of Women's Projects # of LDC's # of Contr. Acceptors	8	8	7	6	6
			7	7	6	4	4
(7) Contraceptive service projects including voluntary Sterilization undertaken in 25-35 LDC's.	55-65 service projects providing services to 1,00,000 people.	} # of Service Projects # of LDC's New Acceptors Continuing Acceptors Total Acceptors	119,576	144,815	113,235	89,636	87,020
			43	55	88	94	100
			22	23	26	30	34
			500,000	356,065	898,898	963,141	753,585
			200,000	306,315	433,780	346,482	336,823
	<u>700,000</u>	<u>662,380</u>	<u>1/ 1,332,678</u>	<u>1,309,623</u>	<u>1,090,418</u>		
(8) IEC Programs in 12-18 ODC's.	15-20 IEC projects implemented.	} # of IEC Projects # of LDC's	14	12	9	8	5
			7	9	4	6	3
(9) Management and Program related technical assistance to LDC projects; emphasis on use of LDC-source consultants.	6,000 person-days T.A. provided to grantees.	} # of Person Days LDC consultants # of LDC's # of Person Days FPIA TA (estimated) # of LDC's	6,793	3,850	5,401	7,513	4,091
			20	16	18	22	17
			436	1,211	978	1,476	1,600
			30	41	35	40	32
(10) FP information and service programs for adolescents in 5-10 LDC's.	10-20 projects for adolescents implemented	} # of Youth Projects # of LDC's # of Contr. Acceptors	2	4	4	7	6
			2	3	3	7	
			4,036	5,000	30,450 <u>2/</u>	41,450	78,724

1/ Peak attributed to initiation of new projects; Brazil and Mexico

2/ Increase ascribed to start of CORA Adolescent Program; Mexico

See Also Annex C for in-depth description  
of grantee accomplishments

\* estimated projections based on 7/1/81 - 12/31/81 data

## II.B. PROJECT DESCRIPTION

This Project Paper (PP) provides for the continuation of activities started in FY 1971 to encourage private sector involvement in the delivery of voluntary family planning services. AID support for such programs has been based on two fundamental principles: voluntarism and informed choice. AID does not support programs in which there is any element of coercion of individuals to practice family planning or to accept any particular method of contraception. Neither does AID support abortion, services, equipment, motivation or any information, education, lobbying, training or communication activities that seek to promote abortion as a method of family planning.

Within this framework, the proposed grant requires FPIA to support only those family planning activities, including Natural Family Planning (NFP) programs that adhere to U. S. legislative requirements and are within the medical and social context of a particular country.

Accordingly, during the next five years, Planned Parenthood Federation of America/Family Plannin~ International Assistance (PPFA/FPIA) plans to provide technical and financial assistance to about 100 family planning/population service, information and training projects in 40-50 countries and to distribute family planning commodities to men and women through existing institutions in 50-60 developing countries. (See Annexes D and G).

FPIA project assistance will be directed primarily to non-government institutions, including charitable and church-related organizations, women's and youth groups and community services organizations in the less developed countries. Some assistance will also be provided to develop the family planning resources and services of government organizations, particularly in Maternal and Child Health (MCH) and Rural Health services.

As a result of FPIA assistance, recipient organizations/institutions will integrate family planning and population information and services into their programs and thereby significantly expand the availability of family planning services and information to poor rural and urban populations.

By the end of this project it is expected that over 5 million persons will have accepted family planning services from FPIA-assisted organizations/institutions, and over 10 million persons will have been reached by FPIA-assisted Information, Education and Communication (IE&C) activities.

Project goals, targets, outputs, inputs, assumption and means of verification are specified in the following project description. The description has been graphically arranged to facilitate comparison of project objectives and events; to illustrate interrelationships and to permit tracking of requirements needed for attaining end of project goals.

A detailed summary of Project Verifications and Assumptions appears on page 18.

## Part II.B. Detailed Project Description

The description appearing below has been arranged to facilitate comparison of project objectives and events; to illustrate their interrelationships and to permit tracking of requirements needed for attaining end of project goals.

### NARRATIVE SUMMARY

### OBJECTIVELY VERIFIABLE INDICATORS

### IMPORTANT ASSUMPTIONS

#### Program or Sector Goal:

#### Measures of Goal Achievement:

#### Assumptions for Achieving Goal Targets:

The goal is twofold:

Enhance the freedom of individuals to choose voluntarily the number and spacing of children and encourage population growth consistent with the growth of economic resources/productivity

Change in age-specific fertility rates in developing countries

Sustained economic development and the achievement of a decent life for LDC citizens can only occur when population growth no longer outpaces economic progress

The two parts of this goal are reciprocal. Voluntary family planning programs provide individual couples with the knowledge and means to freely plan their family size in accordance with their own needs, convictions and the latest medical information. The ability to determine freely the number and

In general terms, the goal will be attained when excessively high birth rates in developing countries are reduced to levels in keeping with the ability of parents, their communities and society to provide for basic human needs. Progress towards this goal can be measured from the following indices:

(1) Increased numbers of total, new and continuing family planning users as measured through timely and reliable family planning program data (Project and clinic performance records), as available or as collected and analyzed through grantee assistance when necessary.

Implicit in this goal are several assumptions:

(1-a) Individuals and couples should be able to decide freely the size of their families; and,

(1-b) Voluntary Family Planning Programs are needed and wanted by citizens of the Third World.

Part II.B. (Cont)

NARRATIVE SUMMARY

Program or Sector Goal:

The goal is twofold:

Enhance the freedom of individuals to choose voluntarily the number and spacing of children and encourage population growth consistent with the growth of economic resources/productivity

spacing of one's children allows the individual greater potential to take advantage of opportunities for improving skills seeking employment and increasing income. Experience has shown that when couples can freely determine the number and spacing of their children, they tend to have smaller families and population growth rates tend to decline. Further, when aggregate national wealth and population are in balance, individual

OBJECTIVELY VERIFIABLE INDICATORS

Measures of Goal Achievement:

Change in age-specific fertility rates in developing countries

- (2) Declining fertility, population growth rates where these can be calculated from vital statistics, census data or economic development reports.
- (3) Increased contraceptive prevalence
- (4) Social indicators such as increased awareness and knowledge of family planning and attitudinal changes towards limiting fertility and towards the desirability of smaller families measured through surveys and/or other evaluative techniques.

IMPORTANT ASSUMPTIONS

Assumptions for Achieving Goal Targets:

Sustained economic development and the achievement of a decent life for LDC citizens can only occur when population growth no longer outpaces economic progress

- (2) Excessive population growth has a negative impact on the standard of living and on social and economic development.
- (3) Availability of family planning programs will result in a decline of fertility, and, in turn, reductions in population growth and unemployment. This will benefit individuals, families, communities and society in general.
- (4) In keeping with U.S. strategic as well as humanitarian interests, AID will continue to help LDC governments achieve economic development and support their citizen's efforts to attain a better life for themselves and their children.

Part II.B. (Con't)

NARRATIVE SUMMARY

Program or Sector Goal:

The goal is twofold:

Enhance the freedom of individuals to choose voluntarily the number and spacing of children and encourage population growth consistent with the growth of economic resources/productivity

families tend to have better prospects for education, employment and health. This, in turn, translates into greater family stability, food sufficiency and higher standards of living. By providing Family Planning commodities, financial and/or technical assistance, the AID program augments other development efforts e.g. health, education, agriculture that are also needed for economic growth and productivity.

OBJECTIVELY VERIFIABLE INDICATORS

Measures of Goal Achievement:

Change in age-specific fertility rates in developing countries

(5) Increased program activity as measured through number of projects, clinics, trained personnel, etc.

IMPORTANT ASSUMPTIONS

Assumptions for Achieving Goal Targets:

Sustained economic development and the achievement of a decent life for LDC citizens can only occur when population growth no longer outpaces economic progress

(5) While external resources can materially assist family planning programs, there must be genuinely indigenous sponsorship, management and operation. Involvement of women in the design, implementation and evaluation of family is especially important.

Family Planning International Assistance (FPIA) has demonstrated its ability to provide family planning commodities, financial and technical assistance and will continue to help citizens of less developed nations control their fertility through the initiation and development of worthwhile, cost effective project activities.

## 2. Project Purpose

TO EXTEND THE AVAILABILITY OF FAMILY PLANNING SERVICES THROUGH EXISTING MEDICAL, SOCIAL AND WELFARE PROGRAMS OF LESS DEVELOPED COUNTRIES

Of the many challenges confronting developing countries, rapid population growth impedes achievement of development objectives by imposing burdens on economies presently unable to provide sufficient goods and services for the growing population. Family Planning assistance materially advances social and economic development; enhances individual freedom to choose voluntarily the number and spacing of children; and provides critically important health benefits for mothers and young children. This project extends family planning through existing networks of medical, social and welfare programs in developing countries. Special emphasis will be placed on private voluntary agencies as instruments to promote support for and initiate and maintain family planning services.

FPIA will provide assistance and interim support to encourage wider adoption of family planning practices, extend knowledge leading to acceptance of family planning practices and services, develop resources and improve management of local organizations/institutions in their delivery of population/family planning services as appropriate through medical, MCH, social action, commercial and/or other innovative delivery systems.

Specific criteria for selection and development of FPIA-assisted activities are indicated in Annex A entitled FPIA Significance and Effectiveness. Selection of FPIA-assisted projects will be facilitated by consultation between FPIA representatives and relevant personnel of U.S. Missions located in the country-sites of FPIA programs. These consultations will enable the U.S. Mission to familiarize

FPIA with prevailing host country political, social and cultural conditions possibly affecting development of population projects; and to acquaint FPIA staff with U.S. population assistance and country development support strategies for the host country.

FPIA staff will inform Mission personnel regarding FPIA programs currently underway in the host country, as well as projects proposed to FPIA by local institutions/organizations. (In most instances these consultations will involve the relevant FPIA Regional Director and pertinent Mission staff, although all visiting FPIA representatives are requested to consult with Mission personnel during their LDC visits.)

In selecting specific projects in LDC's (consistent with the significance and effectiveness assessments described in Annex A and prior Mission consultation), FPIA will pay strong attention to the potential ability of the recipient to continue family planning activities after termination of FPIA funding support. This likelihood is facilitated by the FPIA policy of seeking to integrate family planning components into the ongoing activities of existing organizations, thereby utilizing existing infrastructures, personnel, etc., to participate in the family planning activity.

FPIA will however, assign higher priority to projects which have a greater prospect for continuation/expansion beyond the time limited period supported by FPIA seed monies.

2.a.

Conditions indicating that project  
has been achieved. End of  
Project status.

FPIA-assisted organizations/institutions have assumed increased leadership and financial responsibility for their own population/family planning programs.

- (1) Integration of family planning services into the programs of FPIA-assisted Health/FP organizations/institutions in over 35 LDC's.
- (2) Over 50 LDC family planning projects\* funding their own program requirements.
- (3) Increased prevalence of contraceptive usage in LDC's. (2.5 million new acceptors)
- (4) 5-10 training programs (1,200 physicians, paramedicals and project managers trained annually.

Assumptions for Achieving  
Project Purpose

FPIA assistance will stimulate private and public sector LDC organizations/institutions to initiate successful family planning programs in their respective countries.

- (1) Provision of selective and limited commodities, financial and/or technical assistance will act as a stimulus to the increased spread of family planning awareness and knowledge, the development of family planning leadership and infrastructures, and an increasing availability of efficient and effective service programs.
- (2) Hospitals, public health centers, clinics, schools and social action/improvement programs which are developed and maintained by non-governmental organizations are highly qualified to provide, improve and expand family services. Since these organizations are in the forefront of social change, they can innovate, reach decisions and act quickly, and accept foreign assistance in instances where the governmental sector is more restrained.
- (3) Private, voluntary and/or charitable organizations, by virtue of their independence from government programs, are able to participate in objective evaluation of their programs. Such organizations are able to provide critical important data for program improvement and can assume a leading role in promoting the utilization of evaluation in the improvement of program operations.
- (4) FPIA through its subgrantees will not duplicate activities of other organizations or of governments, but will supplement and complement such activities as required, through constant communication and consultation.

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\* No longer receive FPIA funding.

3.a. Project Outputs:

- (1) Reorganize/relocate FPIA Regional Offices to accommodate changing AID strategies and renewed emphasis on serving African and Latin American countries.
- (2) Family planning commodities distributed to men and women through institutions and agencies in 50 to 60 LDC's.
- (3) Family Planning service projects including FP/MCH clinic, community based distribution (CBD) and/or voluntary sterilization (VS) projects undertaken in 30 to 40 LDC's.
- (4) Family planning Information Education and Communication (IE&C) projects in 3-5 LDC's.
- (5) Women's projects, including income-generating components, implemented in 9-12 LDC's.
- (6) Family planning information and service projects for adolescents in 9-12 LDC's.
- (7) Physician and paraprofessional training in 5 LDC's.
- (8) Program management and technical assistance provided to LDC projects/institutions and cooperating agencies.

Magnitude of Outputs :

- (1) Effectiveness of FPIA Headquarters and Regional offices as determined by requests for services, performance reports, measured against grant objectives
- (2) 120 million cycles oral contraceptives; 370,000,000 pieces of condoms and \$5.5 million of other contraceptives and related FP supplies/equipment distributed.
- (3) 25 FP/MCH clinic; 35 CBD and 10 VS service projects providing services to 1,000,000 people.
- (4) 1-5 IE&C projects implemented.
- (5) 5-10 projects implemented through women's organizations.
- (6) Funding of \$500,000 projects through and/or for adolescents (5 projects).
- (7) Up to 10 projects training 200 physicians; 1,000 paraprofessionals and 15 managers of family planning projects.
- (8) 5,000 person days TA provided to subgrantees; over 50% of TA will be provided by LDC consultants.

Assumptions for achieving outputs:

- (1) Sufficient funds and commodities will be available to support activities.
- (2) FPIA's project review, significance and effectiveness assessments will assure selection of projects with the greatest potential for success.
- (3) Host country acceptance will permit introduction and/or expansion of FP services.
- (4) Host governments/U.S. country Missions will sanction proposed project activities.
- (5) Host country institutions/agencies will develop leadership and management for sustaining FP services after phase out of FPIA funding assistance.

PROJECT INPUTS3.b. Project Inputs:

(1) <u>U.S. Inputs</u>	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>	<u>FY 1986</u>	<u>FY 1987</u>	<u>TOTAL FY 1983-1987</u>
<u>PPFA Costs:</u>						
Salaries	\$1,632,000	\$1,773,454	\$1,888,729	\$1,805,901	\$1,901,950	\$9,002,234
Fringe	270,383	298,320	326,072	311,772	328,354	1,534,901
Consultants	40,000	40,000	45,000	35,000	40,000	200,000
Travel	513,020	564,322	620,754	589,716	620,754	2,908,566
Other Direct Costs						
Headquarters	722,309	713,197	770,253	824,171	770,253	3,800,183
Regional Offices	437,295	465,719	493,662	539,079	518,345	2,454,100
<u>LDC Costs:</u>						
Small Grants	75,000	75,000	75,000	75,000	75,000	375,000
Subgrants/ <sup>1/</sup> subcontracts	7,006,323	6,903,186	8,192,415	8,887,459	9,226,599	40,929,305
Commodities						
Kits, medical supplies, etc. <sup>2/</sup>	900,037	850,000	850,000	750,000	800,000	4,150,037
Contraceptives <sup>3/</sup> (orals and condoms)*						
Freight	975,000	1,000,000	975,000	925,000	950,000	4,825,000
<u>Indirect Costs:<sup>4/</sup></u>						
@ 16%	578,433	616,802	663,115	656,902	668,745	3,183,997
@ 5%	100,000	100,000	100,000	100,000	100,000	500,000
<b>TOTAL</b>	<b>\$13,250,000</b>	<b>\$13,400,000</b>	<b>\$15,000,000</b>	<b>\$15,500,000</b>	<b>\$16,000,000</b>	<b>\$73,150,000</b>

Footnotes:

1/ In addition to the 81 projects which FPIA expects to continue through CY 1983 FPIA intends to commence support for 24 new projects in CY 1983, at a cost of \$1,726,604 or approximately \$72,940 per project.

2/ Distributed as follows: 31.0% for medical kits; 51.0% for other contraceptives; 14.9% for IE&C equipment and materials; 3.0% for medical equipment and miscellaneous.

3/ Oral Contraceptives and condoms will be provided in-kind to PPFA/FPIA as follows:

FY 1983: 20 million cycles oral contraceptives (OCs);  
60,000,000 condoms;

FY 1984: 22 million cycles OCs; 77,000,000 condoms;

FY 1985: 25 million cycles OCs; 75,000,000 condoms;

FY 1986: 26 million cycles OCs; 75,400,000 condoms;

FY 1987: 28 million cycles OCs; 80,000,000 condoms.

Totals 120 million cycles OCs; 370,000,000 condoms

Oral Contraceptives - Average estimated cost FY 1983-1987 at  
\$220,000 per million cycles = \$26,400,000

Condoms - Average estimated cost FY 1983-1987 at  
\$61,300 per million pieces = \$22,681,000

Total estimated IN-KIND Contribution: \$49,081,000

4/ Calculated at 16% of all budget lines except commodities, freight, small grants and subgrants/subcontracts; and 5% of small grants and subgrants/subcontracts.

(2) Host Country Inputs:

FPIA's basic mission is to selectively allocate scarce resources to family planning programming. Because resources are limited, FPIA places priority on the development of innovative, demonstration-type subprojects. Hence, the emphasis in subproject development is to provide seed money for programs that stand a chance of future funding from other sources. FPIA makes clear to its subgrantees that funding is for a limited number of years and that they must look for alternative funding sources. FPIA also has as a priority the integration of family planning activities into the ongoing programs of organizations. This approach reduces funding needs and enhances the likelihood that family planning work will continue after the termination of FPIA support.

Specific contributions from host country agencies vary widely from country to country and project to project. Generally included are partial project funding; in-kind commodities and other project-related supplies and equipment; donated clinic, and/or office space; personnel costs and the basic administrative infrastructure, overhead costs etc. The contributed share of indigenous organizations is expected to increase annually during the period of FPIA assistance, and upon phaseout of FPIA assistance, is expected to cover all project costs with the possible exception of expendable contraceptives. This strategy has worked successfully with many FPIA-assisted organizations and subprojects.

(3) Other Inputs:

Contributions from other agencies and organizations to support PPFA/FPIA's international programs over the 1983-87 period will total approximately \$1,250,000 from foundations, private individuals and from Planned Parenthood Federation of America. In addition, PPFA will raise approximately \$1.5 million for supporting other international programs through International Planned Parenthood Federation (IPPF). During this period, PPFA will also receive approximately \$400 million from U. S. domestic and other U.S. government (HHS and state/local government jurisdictions) for support of PPFA activities in the U.S. through state and local affiliates of PPFA.

As AID regional and bilateral budgets increase, it is possible that some Regional Bureaus and Missions may want to transfer additional funds into the S&T/POP account for supporting additional country-specific subprojects under the centrally-funded Cooperative Agreement with PPFA/FPIA.

In these instances, the Regional Bureau and USAID officers will work closely with the S&T Program Coordinator(s), the S&T/POP Cognizant Technical Officer (CTO) and the Chief PE Contract Management Officer to ensure that the activities being funded are within the scope and time frame of the project and that the additional funds can be accommodated under the existing Cooperative Agreement funding ceiling.

4. PROGRAM DESCRIPTION - VERIFICATIONS AND ASSUMPTIONS

<u>Goals &amp; Objectives</u>	<u>Means of Verification</u>	<u>Important Assumptions</u>
Enhance the freedom of individuals to choose voluntarily the number and spacing of children and encourage population growth consistent with the growth of economic resources/productivity	<ol style="list-style-type: none"> <li>1) Family Planning Program data</li> <li>2) Census data</li> <li>3) Sample Surveys</li> <li>4) Vital Registration Data</li> </ol>	As stated - pages 9-11
Project Purpose - extend the availability of family planning services through existing LDC institutions	<ol style="list-style-type: none"> <li>1) Subproject Reports and evaluations</li> <li>2) On-site inspections of</li> <li>3) Verification of contraceptive availability and prevalence.</li> </ol>	As stated - page 13
Project Output: - Commodities, CBD projects, information, education, women's and training projects	<ol style="list-style-type: none"> <li>1) Grantee financial, commodity and program reports.</li> <li>2) On-site inspections by independent evaluators, USAID/Embassy Population Officers and/or AID/W staff</li> </ol>	As stated - page 14

Project Inputs - A.I.D. - \$000's:

1983	1984	1985	1986	1987
13,250	13,400	15,000	15,500	16,000

1) PIO/T's

Grantee has demonstrated capacity to carry out work.

2) Evaluations

3) Financial and Program reports

4) Vouchers

Funds will be available for project implementation.

5) Travel records

Other donor support not available for project.

Part III. Implementation Arrangements:

A. FPIA and AID Administrative Arrangements

1. FPIA

a. Organizational Structure

FPIA, the International Division of the Planned Parenthood Federation of America (PPFA) is an integral component of the Federation. The PPFA Board of Directors has appointed an International Affairs Committee which oversees FPIA operations and there is a constant interchange between this committee, FPIA and senior PPFA staff. The PPFA Vice President for Medical Affairs also serves as the FPIA Medical Director; the PPFA Vice President for Operations also is intimately involved in FPIA operations. Both of these individuals, as well as the PPFA President, assist FPIA in reviewing project proposals, requests for commodities, etc. In turn, the FPIA Chief Operating Officer participates in PPFA senior staff meetings and interacts with many PPFA departments including Financial Management, Internal Audit, Information and Education, Personnel, Resources and Administration. These departments provide the administrative support required for FPIA to effectively carry out its program responsibilities.

b. General Responsibilities

FPIA's primary responsibility is to develop indigenous institutional capabilities for planning and administering program services. This is accomplished by disseminating information and providing technical assistance and contraceptive commodities to subrecipients. FPIA will be responsible for developing strategies, allocating resources and administering assistance to activities aimed to achieving the objectives of the project described in Part II above and in full compliance with A.I.D. policies and guidelines on sterilization and prohibition of abortion.

c. Program Planning and Management

The PPFA Board of Directors, the International Affairs Committee and PPFA's Vice Presidents of Medical Affairs, Operations and International Programs will continue to review/approve subproject proposals and contribute to the general policy direction of FPIA's international program. FPIA's International Project staff at New York Headquarters and Regional Office Representatives will continue to be responsible for program planning and execution under the overall direction of the PPFA/FPIA International Affairs Committee.

Actual management\* of the Cooperative Agreement and its activities will be carried out by the professional and support staff at PPFA/FPIA's New York Headquarters and FPIA's Regional Offices in Nairobi, Kenya (Africa R.O.); Dacca, Bangladesh (Southwest Asia R.O.); Manila, Philippines (East Asia South Pacific R.O.) and Miami, Florida (Latin America R.O.).

2. A.I.D.

a. Management Responsibilities

A.I.D. project management responsibilities for this activity are in accordance with A.I.D. Handbook 13, "Cooperative Agreements" dated December 31, 1981.

Responsibilities of the A.I.D. Agreement Officer as described in the Handbook are exercised by the relevant Contract Officer in the Office of Contract Management, Bureau for Program and Management Services. Responsibilities of the Project Officer (manager) as described in the Handbook are exercised by the Cognizant Technical Officer (CTO) in the Office of Population, Bureau for Science and Technology.

In furtherance of these responsibilities, the Office of Contract Management has delegated to the Office of Population authority to receive, review and approve the specific subgrantee (Subproject) proposals proposed by FPIA under the A.I.D. Cooperative Agreement. (Exceptions to this delegation include subagreements having a value of \$75,000 (up from \$50,000) or more, and subcontracts executed by FPIA. In these instances, the Offices of Population and Contract Management must both approve subagreements/subcontracts.)

\*The most objective and recent information regarding FPIA's management capability was contained in the June 1981 evaluation report of FPIA prepared under the auspices of the American Public Health Association. The report commended FPIA: "As being one of the best managed and most capable organizations involved in family planning." It cited FPIA for its excellent management system and for introducing and using its program of Management by Objectives (MBO) worldwide. It suggested that FPIA's management system "can and should be a model for other family planning donor agencies," and recommended that AID continue to support the FPIA program for at least the next five years.

b. Subproject (Subgrant) Responsibilities

Subproject review is coordinated by the Cognizant Technical Officer in the Office of Population, and is undertaken by relevant technical and program operations divisions of the population office, the pertinent A.I.D. Regional Bureau/country desk officer; and the USAID Mission and/or Embassy in the country site of the proposed subproject.

No subproject proposals are approved by the Office of Population without A.I.D. Regional Bureau and country Mission review\* and concurrence or before all recommended revisions/alterations in the proposed subproject activities have been endorsed and/or incorporated in the subproject description.

Non country-specific subproject proposals, including those which may require the purchase of supplies and equipment\*\* for worldwide programs may be approved by the Cognizant Technical Officer without Mission or AID Regional Bureau concurrences, with the exception of Contract Office Approval as noted above.

The Office of Contract Management will receive from FPIA a financial summary of all subprojects approved by the Office of Population during each quarter. It also receives copies of all subprojects having a value of \$75,000 or more and approved by the Office of Population, the respective Mission, bureau, etc.

\* Upon completion of AID/W review of subproject proposals, each proposal is submitted via unclassified air pouch or summary cable to the relevant AID Mission or Embassy for in-country review and consultation, as necessary, with the host government.

\*\* In conformance with conditions specified under Index of Standard Provisions for Non-U.S., Non-Educational Subgrantees, Section 12A.

## B. Implementation Plan

Since 1971, FPIA has maintained systems and procedures for identifying, developing and implementing project activities in support of family planning programs in LDC's in accordance with AID objectives and priorities. The kinds of activities FPIA has selected to support and the manner in which that support has been given has been found by A.I.D. and external evaluators to be suitable and effective. In addition, FPIA's private status, broad flexibility and speed of action, international reputation, and relationship to church organizations (e.g. Church World Service) have afforded FPIA a significant measure of access and acceptability in the less developing countries. In countries where there are no U. S. bilateral agreements, FPIA continues to serve private and/or public sector family planning/population programs in keeping with U.S. interests.

Having demonstrated its competence in allocating A.I.D. resources and administering assistance to a broad spectrum of family planning programs, FPIA proposes to continue the task of developing and assisting LDC projects through FY 1987.

Specifically, during the next five years, FPIA plans to: distribute family planning commodities to men and women through institutions in 50 to 60 LDC's; provide technical and financial assistance to some 80 to 100 service projects; 5 to 15 information/education projects; 10 to 20 training projects and up to 50 womens' organization projects.

FPIA funding of LDC subproject activities will be through the subgrant mechanism with FPIA proposals processed through the PPFA International Affairs Committee and A.I.D. approvals in the usual manner. FPIA, as an international division of PPFA will be encouraged to seek additional funding from other sources as it sees fit.

From time to time, A.I.D. may suggest to FPIA technical and/or advisory services or other activities it may wish FPIA to undertake. (However, FPIA has the option to decline such suggested activities.) FPIA will then develop and submit to A.I.D. a proposal in accordance with established procedures.

## C. Implementation Procedures

### 1. Proposal Requirements

Investigation of subproject possibilities and preparation of subproject proposals and supporting information will be FPIA's responsibility in consultation with AID/W. FPIA will continue to apply basic criteria (see pages 23, 24) and understanding of A.I.D. priorities in selecting those subprojects which will receive funding, commodity, and technical assistance under the AID cooperative agreement.

To be eligible for financial assistance under the Cooperative Agreement, each subproject must be described in a written proposal which shall include the following information:

Summary Section

Project Title  
Subrecipient (Subgrantee) Agency/Authorized Official  
Project Director  
Budget Duration  
Budget Amount  
Commodity Value  
Summary of Objectives

Narrative

Program Need and Background  
Project Significance Statement  
Project Effectiveness Statement  
Subgrantee Capability Statement  
Project Activity Plans  
Work/Implementation Plan  
Project Monitoring & Evaluation Plan  
Job Descriptions  
Commodity Projections

Budget

U.S. Costs (FPIA Obligations)  
In-Country Costs (LDC Contribution)  
Other: Agency Contributions

Further conditions for A.I.D. assistance require each subproject to be in conformance with the terms and conditions of the Cooperative Agreement and meet at least one of the following four criteria:

- o the subproject will initiate, continue or expand family planning service delivery in a developing country or countries;
- o the subproject will initiate, continue or expand information education and communications activities in support of family planning;
- o the subproject will expand and/or upgrade technical, managerial and/or service delivery skills through training or orientation programs, conferences, seminars or workshops;
- o the project will result in the development of new techniques and/or methodologies and approaches with prospective application to other family planning programs.

As for timing, each subproject proposal must be submitted to the Cognizant Technical Officer in the Office of Population A.I.D at least sixty days before the effective start or renewal date of each subproject.

FPIA will make suitable adjustments for subproject proposals in those countries in which the government and/or USAID lead-time requirements for approval exceed 60 days. Normally new subprojects are funded for twelve or eighteen month periods. For each subsequent refunding period, the proposal approval and subproject agreement processes are repeated.

## 2. Approval Criteria

FPIA will judge the relevance and feasibility of proposals from developing countries in terms of the objectives of this Project; PPFA/FPIA's corporate policies and standing guidelines and the availability of resources. AID approval will be based on its determination that each proposal is consistent with AID Policy Determinations and Guidelines; that the country of implementation is eligible for U.S. assistance\*\* and is one in which the activity is important; and that the subproject appears to be feasible and at an acceptable level of cost effectiveness.

A.I.D. requires assurance that the government of the country concerned approves of the proposed subproject. This may be formal, written approval or implicit in the evidence of the subgrantee's prolonged family planning activities or the government's use, support or sanction of the subgrantee's services. In countries where the government permits private-sector family planning services (including voluntary sterilization) to exist but -- for whatever reasons -- is not willing to formally sanction family planning activities (including voluntary sterilization), communication to AID/W of the U.S. Mission's determination that such is the case will satisfy this requirement.

## 3. Approval Procedures

a. FPIA will submit subproject proposals (as described in III.C.1 above) to the AID Cognizant Technical Officer. The latter will circulate copies for review and concurrence to the concerned Office of Population and regional bureau technical officers and to the U. S. Mission or Embassy population officer. These concurrences, based on the criteria cited in III.C.2 will form the basis of AID's written approval to FPIA.

b. Upon receipt of AID approval, FPIA will execute a Grant Award Letter (GAL). The signed GAL represents formal agreement that the subgrantee accepts the terms and conditions of the FPIA grant. The GAL specifies project objectives and work plans, mutual responsibilities, volunteerism and informed consent (if voluntary sterilizations services are involved), accounting and audit requirements, prohibition of abortion covenants and budget. Any change in the Standard Contractual provisions for subgrants\* requires prior approval of the AID Contract Management Office.

\* Index of Standard Provisions - Non-U.S. Grantees and Subgrantees; Non-Profit Organization - other than educational institutions, A.I.D. 1420-54 (2-82).

\*\* In accordance with geographic Area Code #935, AID Handbook #18, Appendix D, Section III.

c. Small Grants under \$7,500 may be awarded by FPIA without prior A.I.D. approval for short term specialized training; participation in meetings, seminars of developing country persons; equipment to developing country institutions and agencies and local procurement of technical or educational materials. For surgical equipment FPIA will keep on file qualifications of the surgeon) who will use the equipment, data on the physical facility in which the surgical procedures will be performed, and the recipient's certification that services will be provided only to persons requesting them on an entirely voluntary basis.

d. For purchase of local commodities by a subgrantee, the country where the subgrant is located is considered a Cooperating Country. Hence, local procurement shall be governed by the provisions of Handbook 15 and Standard Provision 11 -- "Local Cost Financing with U.S. Dollars."

4. Implementation Schedule (see Annex I)

5. Accountability

For subgrants to foreign institutions, FPIA shall follow the Standard Provisions set forth in Handbook 13, Appendix D. In addition, FPIA will maintain books, records, documents and other evidence and accounting procedures and practices sufficient to reflect properly that any funds provided by AID were expended exclusively for the purposes of the subgrant. Such records shall be maintained for a period of three years following the expiration of the subgrant.

FPIA shall ensure that all subgrants totalling \$35,000 or more per year will be audited on an annual basis and that ten percent (10%) of all subgrants totalling less than \$35,000 per year will be audited on an annual basis selected at random. FPIA shall further assure that the annual audits of subgrantee records shall be conducted by an independent public accountant with a national certification, similar or equivalent to a certified public accountant. If FPIA determines that an audit is not possible or feasible, it will submit to the Contracts Management Office of A.I.D. alternatives which will achieve the same objective. FPIA will include in each of its subgrants a clause by which FPIA assures A.I.D.'s right to audit. FPIA shall also require that the subgrantee make available any further information that is requested by FPIA; with respect to questions concerning the audit. The report of independent audit shall be submitted to FPIA and will be retained by FPIA as part of the subgrant records.

For all subgrant institutions using A.I.D. funds to provide voluntary surgical contraceptive services, FPIA will ascertain that the institution providing voluntary sterilization services maintains patient records for three years and will make them available, as necessary, for inspection and verification by FPIA. These records should include the following identifying data:

1. Name of patient
2. Residence of patient
3. Age and sex of patient
4. Number of pregnancies and number of living children
5. Date procedure performed and location
6. Name of procedure
7. Notes on physical findings
8. Signature of physician performing procedure
9. Documented evidence of informed consent

## 6. Program Continuity

FPIA and AID share the objective of assisting Family planning programs until they can be supported fully by domestic resources. However, FPIA's encouragement of subgrantees to become self-supporting occurs in the poorest of economic environments. Most FPIA subgrantees are private sector organizations and institutions. Most are incapable of generating adequate funds to become totally independent. None is capable of raising adequate funds for procuring/importing contraceptive commodities in the amounts needed to maintain their service programs.

FPIA has neither the mandate nor the capacity to support long-term, sustained programs on a regular basis. Once established and effectively operational, most FPIA subprojects must either become self-sustaining or enlist other support. This has been accomplished by mixing income-generation schemes with other donor assistance. In few instances however, were former subgrantees able to maintain services without outside contraceptive commodity assistance.

During the proposed contract period (1983-87), FPIA will be encouraged to guide subgrantees in mobilizing domestic resources. It will not be required to apply arbitrary subproject termination schedules that may interrupt or deprive clients of contraceptive services.

## 7. Country Policies

Family Planning programs, including voluntary sterilization activities must be carried out within the framework of host country policy and practices. In monitoring the consistency of voluntary sterilization programs with local policy and practices, FPIA and AID will take particular note of the program activity among cultural, ethnic, religious or political minorities to ensure that the principle of informed consent is being observed and that the rights of minorities are protected.

## 8. Site Visits and Travel

Beyond their necessity for project identification and development, project monitoring, and medical and technical assistance, site visits by staff members are valuable for keeping program personnel in touch with reality, developing relationships, transferring project planning and management skills, and enhancing interest in and understanding of permanent contraception.

Newly appointed personnel accompany experienced staff members as part of a planned staff development program. Similarly, observation tours by PPFA International Affairs Committee members prepare them to make informed judgements in their tasks of proposal approval and policy and standards formulation. Standing A.I.D. travel regulations apply, including prior concurrences of U.S. Missions in the countries to be visited and prior approval of grant-funded travel by the A.I.D. Project Manager. Regional FPIA representatives will obtain prior U.S. Mission concurrences directly for travel within their respective regions without AID/Washington approval. However, AID/Washington approval will be required for travel to the U.S. or to other regions.

#### 9. Coordination

FPIA plans its overseas project activities in collaboration with host country institutions and in consultation with USAID/Embassy population officers and AID project managers responsible for assuring that centrally funded grant and contract activities are mutually reinforcing and congruent with host country and AID program objectives.

FPIA maintains close, regular and meaningful coordination with other international donors including International Planned Parenthood Federation (IPPF), Church World Services (CWS) and the International Program Association for Voluntary Sterilization (IPAVS) and The Pathfinder Fund (PF). It uses formal and informal communication links with other agencies in developing countries to ensure that their respective activities complement each other. For example, FPIA and IPPF regularly exchange program information and views and coordinate activities to ensure that their comprehensive programs do not overlap or duplicate each others work. Staff attend briefings about proposed subprojects and the capacity of jointly funded FPIA-IPPF subgrantees e.g. IPPF Family Planning Associations (FPA's) to carry out LDC programs. Before agreeing to provide assistance, FPIA makes certain that the FPA can manage the assistance it receives; that the assistance complements IPPF support and that FPIA's involvement will not affect adversely the collaborating FPA program.

In addition to regional consultations, FPIA and IPPF representatives meet once a year in London and New York. At these meetings, the representatives meet with senior staff and country desk officers to discuss program plans and strategies continent by continent. Similar AID meetings with the international donors occur each year.

#### III. D. Professional and Consultant Personnel

Curricula vitae of senior staff members (chiefs of the major organizational units or divisions and above at headquarters; expatriate staff at regional offices) and of consultants will be sent to the A.I.D. Project Manager for record purposes. The Project Manager will be provided the opportunity of prior review and comment on the selection of top-level executive staff (currently the positions of Project Director, the Director of Program Operations and the chief medical officer) and U. S. consultants. The posting of expatriate staff to regional offices in developing countries requires the prior concurrence of the respective U.S. Missions.

### E. Reporting

The current AID Grant Agreement with FPIA ends March 31, 1983. Not later than three months after completion of the current Agreement, FPIA will submit to the AID Cognizant Technical Officer a summary report covering Program Year II (July 1, 1981 to June 30, 1982) plus the nine-month period ending March 31, 1983. The twenty-one month report will describe activities, accomplishments and problems encountered during the period reported upon and will present cumulative information on all subproject and commodity assistance provided by FPIA from July 1971 through December 1982. Since the new AID Cooperative Agreement will be effective on January 1, 1983, future AID Reports will be submitted to AID on a calendar or grant year basis. Such annual reports shall be submitted to the AID CTO not later than three months after completion of each Grant period. In addition to the information cited above, each Report should include a critical analysis of its progress being made in achieving the aims of the grant and should indicate in what ways the original plan was followed or should be modified. All financial reports and vouchers for payment and reporting of expenditures will conform to standard AID regulations and procedures.

FPIA will continue to require subgrantees providing services to report promptly to FPIA the facts and circumstances of deaths associated with voluntary sterilization procedures. FPIA will in turn, relay such reports to the PPFA Medical Affairs Officer and the AID Cognizant Technical Officer.

F. Evaluation. Two comprehensive evaluations are planned in the five-year period: on or about July 1984 and July 1986. These proposed dates (tentative) reflect decision points in project management and planning. The evaluations will be conducted by a qualified team of experts or organizations acceptable to A.I.D. and PPFA/FPIA. Evaluation workscopes will be prepared by A.I.D. They are expected to assess the grantee's program management performance and measure progress made by a representative geographical sampling of FPIA subgrantees toward achieving their project objectives.

The evaluation plans may be altered during the course of the project period to conform to A.I.D. directives unrelated to this specific project. Additionally, A.I.D. may request, from time to time, special evaluations of FPIA's management of the grant or of selected subgrant projects according to grant management requirements.

At the end of the project period, PPFA/FPIA and AID, will conduct an in-house comparison of actual accomplishments and expected results as set forth in the Logical Framework Summary of the Project Design.

#### IV. Project Analyses.

A. Social Soundness Analysis. In 1974, the United Nations Bucharest Conference endorsed the thesis that couples and individuals have the basic human right to information, education and means to act on their fertility decisions. In developing countries, the level of commitment to this thesis depends on the existing political, socio-economic, religious and cultural environment and on the assured availability of external resources. Given these realities, "informed choice" translates into a variety of information, education and service programs that focus on improving the health and well-being of the people while bringing population growth into balance with present and future resources.

Access to "family planning" programs is a key factor for improving public health, lowering maternal/child morbidity and mortality and restraining fertility. The primary beneficiaries of these programs are women and children. The ultimate beneficiaries are the developing countries that, by arresting population growth, are better prepared to invest their limited resources in improving the health, productivity and economic well-being of the people while reducing their dependency on other nations for basic supplies and services.

When PFFA entered the international field in 1971, it assisted mostly non-government, often charitable, church-related and/or community service organizations. At that time, it provided information about birth spacing to small groups of urban women. Eleven projects were initiated in eleven different countries.

As improved health and economics became national targets, many developing countries began to discover that different social needs were linked with national growth. The discovery had a pronounced effect on the kinds and magnitude of assistance that was requested of donor agencies during the remaining decade. It afforded further direction to A.I.D. grantees about program priorities. Within this changing environment FPIA retargeted its assistance on activities which reduce excess, unwanted fertility and positively affect social and economic conditions in the developing countries. The activities include:

- Programs for rural people (who comprise almost 80 percent of the world population);
- Programs which improve the role of women (as project managers as well as beneficiaries);
- Programs which extend family planning information and services to adolescents;
- Information, Education and Communication activities which link education more directly to the delivery of family planning services;

- o Low-cost, low-technology provision of voluntary sterilization services (e.g. vasectomy and minilaparotomy) and;
- o Activities which extend the availability of FP services and contraceptive supplies and equipment through existing health/medical facilities and service institutions.

These program activities\* illustrate the major (outputs) areas in which FPIA, collaborating governments and private sector agencies are making investments for the common good. By actively participating in the development and operation of family planning and health-related programs, FPIA and counterpart IDC agencies/institutions are assuming that the quality of life can be improved and that target populations can begin to expect reasonably decent housing, medical attention, education, food supplies and employment opportunities and tangible economic gains. The social changes that are expected to result from family planning programs are beginning to appear in several countries. For example, in Korea, Thailand, Indonesia, Philippines, Chile, Columbia and Mexico more rural and urban women are becoming involved in administering health, contraceptive service and income-generating programs that meet the critical rather than the marginal needs of women. This indicates that freedom from the recurring cycle of childbirth is enabling more women to expand their participation in activities not directly related to childbearing and to find outside employment that provides cash benefits and social rewards. In these countries, the trend is expected to continue since contraceptive prevalence is rising and fertility and growth rates are being lowered.

B. Technical Analysis FPIA assistance is based on voluntarism and informed choice. In this context, FPIA provides individual couples with information needed to decide about desired family size. This includes natural family planning (NFP) methods which rely upon periodic abstinence, as well as methods that require use of contraceptives or surgical procedures. FPIA offers only those contraceptives that have been approved by the U.S. Food and Drug Administration, and adheres strictly to AID policies and sections 104 of the Foreign Assistance Act and 525 of the Appropriations Act, 1982 governing abortion and voluntary sterilization.

Receptivity to FPIA assistance is ubiquitous. To date, FPIA assistance has spanned four continents, involved more than 100 countries and brought together more than 2,600 diverse agencies, institutions and governments in a common effort. Currently, about 1.4 million new and continuing clients are using FPIA-supplied contraceptives. They are being supplied in settings ranging from major medical centers to rural clinics and camps.

\*There is a safeguard in this project against activities being carried out in countries without the knowledge and approval of the respective governments. As part of the approval process, missions are requested to assure A.I.D./ Washington that the host government has indicated their non-objection explicitly or implicitly to proposed subgrants.

The demand for contraception is steadily growing. This is largely attributed to the proven reliability of a broad range of contraceptive interventions that afford effective, low-risk protection for wide varieties of fertile couples. For example, younger fertile women and adolescents seek temporary protection through the use of oral contraceptives, condoms, IUD's, diaphragms, spermicides etc., older acceptors also use temporary means but more couples who have attained their desired family size are turning to low-risk voluntary surgical procedures which are irreversible and afford permanent protection.

Personal selection of a contraception method, therefore, depends upon informed judgements made by delayers or preventers of pregnancy of various ages and socio-economic status. Continued acceptance, however, depends upon the use-effectiveness (of a particular method) actually experienced by each delayer or preventer. Hence family planning providers must give useful prescriptive advice to their clients. This includes information on known failure rates (use-effectiveness) of various contraceptives used by clients of different ages, intentions etc., and the risks associated with alternative methods of temporary and permanent contraception.

The technical data derive mostly from investigations in the developed world. According to a recent study of contraceptive failure within the first year of contraceptive use, the most effective temporary methods are: the pill (97.6%); IUD (95.4%); condom (90.4%); spermicides (82.1%); Diaphragm (81.4%); Rhythm (76.3%). It was also noted that first year failure rates are typically higher for those attempting to delay an unwanted pregnancy than for those wishing to prevent an unwanted pregnancy. As for permanent contraception, both vasectomy and tubal ligation offer the least risk (99+%) effective.

The development of outpatient techniques has lowered the risks and costs of procedures and sharply reduced hospital bed occupancy time. These characteristics have increased the acceptability of surgical sterilization to clients. Thus, both male and female sterilizations performed under local anaesthesia as outpatient procedures are being rapidly accepted in many countries.

In sum, there is a range of technology now available which ensures the availability of effective, low-risk services in a wide variety of FPIA-assisted projects throughout the world.

C. Economic Analysis. Justification for supporting this project is based on evidence that family planning programs have positive economic effects at the family level, and by cumulative effect, at the community and country levels.

Within families, attitudes toward having large numbers of children as insurance against economic insecurity are slowly changing. As of June 1981, Contraceptive Prevalence Surveys conducted in 16 developing countries showed at least 50 percent of currently married women wanted no more children; an additional 30-40 percent wanted another child later, but not now. Thus, 80-90 percent surveyed did not currently want a child. There are powerful health and economic reasons for this. Pregnancy-related risks to the

health and life of women increase dramatically with the mother's age and frequency of childbearing. Weakened physically by successive pregnancies, women know that they are increasingly vulnerable to death during childbirth or to simple infectious diseases at any time. Being undernourished, often anemic and living mostly under poverty conditions, women are ill-prepared to withstand these biological burdens while struggling to provide adequate care and nourishment for their offspring. Similarly, children born to very young or older women, run a much higher risk of death or birth-related disorders.

In most developing countries, the primary income-producing unit is the family, hence the health and productivity of the wife-mother is crucial to the economic viability of the family. The lost income or lost in-kind income consequent to her sickness or death is a real cost; as are the recurring costs for medical care for pregnancy-induced morbidity and costs for medicines and neonatal care. These represent health maintenance costs that could be reduced through child spacing.

In addition, a recent study carried out by the World Health Organization (WHO/PAHO) reported that up to 50 percent of short-stay hospitals and clinics in developing countries are occupied by pregnancy-related cases. Savings here would free up medical facilities, staff and funds for other people who are competing for medical care. In fact, some countries that are implementing national health programs, such as Thailand, have identified anticipated savings in the health sector as an important economic argument for more government support for family planning programs.

Further justification is based on economic effects that are attributable to actual declines in excess fertility and rates of population growth. These effects include changes in the youth-age dependency ratio (less consumers to producers) resulting in higher per capita income and declining rate of increase in demand for government services; greater public outlays for productive investment; increased labor force participation rates; improved labor productivity via better health, nutrition, housing, etc., (by feedback through increased per capita income) and accelerated absorption of idle or underemployed manpower in the labor force.

A family planning program therefore has economic advantages both as a public health and fertility reduction activity. Compared to these benefits however, are economic costs. These costs can be compared to specific project outputs i.e. contraceptive acceptors, infant and maternal mortality levels in order to achieve a cost-per-unit measure. They can also be compared to the ultimate performance measures i.e. the improved quality of life - where these latter can be expressed in some quantifiable economic fashion. Comparing costs to acceptors yields one evaluation; comparing costs to economic benefits of fertility reduction yields another kind of evaluation.

Generally, an economic cost-benefit evaluation is the most desirable. In practice, however the assignment of specific economic benefits to fertility reduction is difficult and controversial. Hence, the most likely economic evaluation procedures for field projects are ones which take the economic benefits for granted and evaluate the costs in terms of some

non-economic measure of ultimate achievement such as births averted; or even evaluate costs in terms of a measure of project accomplishment such as acceptors or couple years of protection.

Since FPIA's worldwide assistance program involves more than 100 subprojects in 30 developing countries, a cost-benefit evaluation of the overall program has not been done. However, data on project acceptors (new and continuing contraceptive users) and couple years of protection are routinely recorded by each FPIA subproject and is available for making some costs estimates.

D. Financial Analysis and Plan:

1. Financial Rate of Return/Viability: This project is not a revenue-producing activity, so an analysis of financial rate of return or financial viability of the subprojects is not attempted here. The project does have an anticipated, though not directly measurable, economic impact via its role in decreasing excess fertility and too-rapid population growth. The positive economic effects of decreased fertility are realized at the family level and, by cumulative effect, at the national and global level. These effects of the project are discussed more fully in Sec. C, Economic Analysis.

2. Recurrent Budget Analysis: The project budget shown on page 34 of this Paper is considered adequate to fund the recurrent operating and maintenance costs assumed by FPIA in conducting this project. It should be noted, however, that FPIA-assisted international activities will be supported nearly completely (approx. 90%) by grant funds derived from AID's Cooperative Agreement with PPFA/FPIA. In providing these grants, AID acknowledges that PPFA/FPIA possesses particular skills in project identification and support, but lacks the financial resources needed to carry out these functions. Conversely, AID acknowledges that PPFA/FPIA would not be able to continue its involvement in this field at the same level of activity in the absence of AID or other-source support. That is, both AID and PPFA/FPIA agree that the purpose of this project is not institution-building or resource-development at PPFA/FPIA, but rather the development and expansion of family planning activities in the LDCs. Consequently, eventual development of a self-sustaining, non-AID funded, financially viable FPIA assistance program is not an objective of this project. Current nongovernment resource availabilities for population activities are not adequate to sustain the necessary level of activity by FPIA and other international assistance agencies in the population fields. (Similarly, other international-service organizations such as CARE and the American Red Cross are able to continue certain activities only so long as the U.S. Government provides funding for these organizations.)

This project does not, therefore include a phase-out schedule, or an estimation of PPFA/FPIA gradual assumption of project costs. It is the intention of AID and PPFA/FPIA to continue a grantor/grantee relationship unprejudiced by PPFA/FPIA's inability to replace most AID-source funds over the life of this project with other-source funds. FPIA will, of course, seek

other donors to expand its activity beyond that described herein; but these other-donor funds are not realistically expected to amount to more than 10% of PPFA/FPIA international programs during the next five years.

3. Financial Plan: Budget projections for the five years of this project are shown in the following tables. Host country financial and in-kind contributions vary from country to country and are undeterminable.

<u>Budget Category</u>	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>	<u>FY 1986</u>	<u>FY 1987</u>	<u>Total</u>
Salaries	\$1,632,000	\$1,773,454	\$1,888,729	\$1,805,901	\$1,901,950	\$9,002,234
Fringe	270,383	298,320	326,072	311,772	328,354	1,534,901
Consultants	40,000	40,000	45,000	35,000	40,000	200,000
Travel	513,020	564,322	620,754	589,716	620,754	2,908,566
Other Direct Costs (Hqs)	722,309	713,197	770,253	824,171	770,253	3,800,183
Other Direct Costs (Regional Ofcs)	437,295	465,719	493,662	539,079	518,345	2,454,100
Small Grants	75,000	75,000	75,000	75,000	75,000	375,000
Subgrants/ Subcontracts	7,006,323	6,903,186	8,192,415	8,887,459	9,226,599	40,929,305
Commodities	900,037	850,000	850,000	750,000	800,000	4,150,037
Freight	975,000	1,000,000	975,000	925,000	950,000	4,825,000
Indirect Costs @16%	578,433	616,802	663,115	656,902	668,745	3,183,997
Subgrant O/H	100,000	100,000	100,000	100,000	100,000	500,000
<b>TOTAL</b>	<b>\$13,250,000</b>	<b>\$13,400,000</b>	<b>\$15,000,000</b>	<b>\$15,500,000</b>	<b>\$16,600,000</b>	<b>\$73,150,000</b>

Over the five-year period, FPIA expects to obligate \$40,929,305 for subgrants/subcontracts. One percent of this amount will pay for subgrant audits. The Latin America region will continue to obligate the largest grant awards and, as such, is allocated 35 percent of the aggregate subgrant budget. The combined East and Southwest Asia regions will have available, over the five-year period, 31 percent of the subgrant budget. The Africa region is scheduled to receive 33 percent of the available subgrant funds. A summary of each region's subgrant program is described below:

Africa: Subgrants will be developed in 18 countries, including several countries in which FPIA has not previously worked. As support for continuation projects phases out in Egypt, Kenya, Nigeria and Sierra Leone, available funds will be utilized for new initiatives in these countries. The CBD design of the Africa projects will continue and increase. Sterilization services and support for indigenous community organizations will increase. FPIA will develop commodity distribution projects in an attempt to provide contraceptives while solving Africa's difficult logistical problems. Should the demand for African CBD projects increase, subproject funds will be reprogrammed from other regions.

Asia: Over the five-year grant period, the combined Asia program portfolio will provide less support to family planning programs in Bangladesh, Indonesia and the Philippines. One cycle of programming in Thailand will be completed by 1986; and, if FPIA successfully relocates its regional office in Bangkok, further programming will have been initiated by that time. Increased support may be made available to well designed service projects in India, Pakistan and Turkey. Programming levels in Nepal, the South Pacific and Jordan are expected to increase as the management capability of current subgrantees strengthens. The trend toward subgrant 16-18 month funding periods will continue. One goal is to make FPIA's project portfolio compatible with and complementary to AID bilateral programs throughout Asia and the South Pacific.

Latin America: During the next five years, FPIA project development may result in an expanded subgrant program in Mexico, Central America and Peru. Mexican projects will emphasize support for services in border areas and the majority of service providers will be private sector organizations. Projects in Brazil and Peru will offer services in areas situated away from the capitals. New project initiatives also will be undertaken in Panama and Bolivia. Support for projects in Guatemala will continue and projects will be developed in El Salvador, Dominican Republic and other Central American nations.

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project:  
From FY 83 to FY 87  
Total US Funding \$73,150,000  
Date Prepared: 7/25/82

Planned Parenthood Federation of America/  
Project Title & Number: Family Planning International Assistance (PPFA/FPIA) - 732-0755

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>Enhance the freedom of individuals to choose voluntarily the number and spacing of children and encourage population growth consistent with the growth of economic resources/productivity</p>	<p>Measures of Goal Achievement:</p> <p>Change in age-specific fertility rates in developing countries</p>	<p>1) Family Planning Program data 2) Census data 3) Sample Surveys 4) Vital Registration data</p>	<p>Assumptions for achieving goal targets:</p> <p>Individuals and couples should be able to decide freely the size of their families; and,  Voluntary Family Planning Programs are needed and wanted by citizens of the Third World</p>
<p>Project Purpose:</p> <p>Introduce and/or extend the availability of family planning services throughout existing medical social and welfare programs in less developed countries</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ul style="list-style-type: none"> <li>■ LDC organizations/institutions have assumed increased leadership and financial responsibility for their own Population/FP Programs.</li> <li>■ Family Planning information and services being provided by indigenous organizations/institutions in 70-100 LDC's.</li> </ul>	<p>1) Subproject Reports/Evaluations 2) On-site inspections of sub-grantee projects 3) Verification of contraceptive availability and prevalence</p>	<p>Assumptions for achieving purpose:</p> <p>Provision of limited commodity, financial and/or technical assistance to LDC agencies/institutions will stimulate development of family planning leadership, FP infrastructure and efficient and effective service programs in the developing countries.</p>
<p>Output:</p> <p>1) FP commodities distributed to men and women in 50 to 60 LDC's. 2) FP Clinic, CDD, and VS projects undertaken in 30-40 LDC's. 3) Womens and adolescents projects in 18 to 24 LDC's 4) FP training projects in 5 LDC's 5) IE &amp; C projects in 3-5 LDC's 6) Management and program-related technical assistance provided to LDC subgrantees</p>	<p>Magnitude of Outputs:</p> <p>1) 120,000,000 oral contraceptives; 375,000,000 pieces of condoms and \$5.5 million of related FP equipment distributed thru local FP agencies. 2) 25 FP/MPH clinic; 35 CDD and 10 VS Service projects. 3) 5-15 IERC projects implemented thru womens organizations 4) 1-5 adolescent projects 5) 10 training projects for 200 physicians; 1000 paraprofessionals and 15 managers of FP projects. 6) 5,000 person days TA provided mostly by Third World Consult.</p>	<p>1) Grantee financial, commodity and program reports 2) On-site inspections by independent evaluators, USAID and Embassy Population Officers and/or AID/W staff.</p>	<p>Assumptions for achieving outputs:</p> <p>Host governments/US country Missions will sanction project activities.  Host country institutions &amp; agencies will develop leadership and management for sustaining FP services after phase-out of Grantee funding assistance</p>
<p>Inputs: FY (000 - rounded) AID</p>			<p>Assumptions for providing inputs:</p> <p>Grantee has demonstrated capacity to carry out work  Funds will be available for project implementation  Other donor support not available for project activity</p>

Budget Category	CY 1983	CY 1984	CY 1985	CY 1986	CY 1987	Total
Salaries	\$1,532,200	\$1,773,454	\$1,588,729	\$1,805,901	\$1,901,350	\$7,501,634
Fringe	270,383	298,320	326,072	311,772	328,354	1,534,901
Consultants	40,000	40,000	45,000	35,000	40,000	200,000
Travel	513,020	564,222	620,754	589,716	620,754	2,908,566
Other Direct Costs (Headquarters)	722,309	713,197	770,253	824,171	770,253	3,800,183
Other Direct Costs (Regional Offices)	437,295	465,719	493,562	539,079	513,245	2,454,120
Small Grants	75,000	75,000	75,000	75,000	75,000	375,000
Subgrants/Subcontracts	7,006,323	6,903,186	8,192,415	8,887,459	9,209,599	40,929,305
Commodities	900,037	950,000	950,000	750,000	800,000	4,150,037
Freight	975,000	1,000,000	975,000	925,000	950,000	4,825,000
Indirect Costs @16%	573,733	615,302	663,115	656,902	663,745	3,173,397
Support C/H	100,000	100,000	100,000	100,000	100,000	500,000
TOTAL	\$13,250,000	\$13,400,000	\$15,000,000	\$15,500,000	\$15,000,000	\$73,150,000

E. Environmental Impact: The primary purpose of this project is to introduce and extend the availability of family planning services through the medical, social and welfare programs of existing LDC institutions/organizations. To achieve this purpose, the Planned Parenthood Federation of America, Inc./Family Planning International Assistance (FPIA) has requested grant assistance from the Agency for International Development (AID) to enable PPFA/FPIA to support LDC projects in the following areas: (1) extension of family planning (FP) programs which improve the status of women; (2) increased training and utilization of paraprofessional personnel; (3) expansion of voluntary sterilization services; and, (4) provision of contraceptive supplies and FP commodities to LDC medical service institutions. The result of PPFA/FPIA assistance efforts in these areas will be a decrease in the fertility of the recipient LDC populations, and a consequent positive environmental impact resulting from decreased demand for/utilization of natural and manufactured resources.